

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-037054

STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No. 317

Primary Registration District No. 500

Registrar's No. 2552

FILED SEP 20 1962

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo</b> b. COUNTY <b>St. Louis</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Sunset Hills</b>		c. CITY OR TOWN <b>Maplewood</b>	
Length of stay in 1b <b>5 Hrs</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Peace Haven Nursing Home</b>		d. STREET ADDRESS (If outside, give location) <b>7322 Elm Ave</b>	
3. NAME OF DECEASED (Type or print) First <b>Flora</b> Middle <b>Marie</b> Last <b>Hesse</b>		4. DATE OF DEATH Month <b>September</b> Day <b>1</b> Year <b>1962</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>4/18/1889</b>
9. AGE (last birthday) <b>73</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (City and state or country) <b>Gasconade Co. Mo</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>Henry Zinn</b>		13b. MOTHER'S MAIDEN NAME <b>Hulda Hengstenberg</b>	
14. NAME OF HUSBAND OR WIFE <b>Wm. B. Hesse</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Mrs Charles Jenkins #8 Westwood Forest</b>	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Unknown natural causes</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>(No medical treatment - Christian Scientist -- complained of soreness and swelling in abdomen for the last 8 months)</b> DUE TO (c) <b></b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			INTERVAL BETWEEN ONSET AND DEATH <b>Unk</b>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour <b></b> a.m. <b></b> p.m. <b></b> Month, Day, Year <b></b>	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <b>8:20 PM</b> to <b></b> and last saw her/him alive on <b></b> Death occurred at <b>8:20 PM</b> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>Raymond F. Harris</b> (Degree or title) <b>Coroner</b>		22b. ADDRESS <b>Clayton, Missouri</b>	
22c. DATE SIGNED <b>9/7/62</b>		23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	
23b. DATE <b>9/4/62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Oak Hill Cemetery</b>	
23d. LOCATION (City, town, or county) <b>Kirkwood, Missouri</b>		23e. DATE RECD. BY LOCAL REG. <b>9-4-62</b>	
24. FUNERAL DIRECTOR ADDRESS <b>Alexander &amp; Sons 6175 Delmar Blvd</b>		25. REGISTRAR'S SIGNATURE <b>John B. Murphy M.D.</b>	

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK  
OR  
TYPEWRITER RIBBON

UNK

STATEMENT BY LICENSED EMBALMER

(No medical treatment - Christian Science -  
the body was embalmed by me, recorded on the reverse side of this certificate was embalmed by me,  
ing in abdomen for the last 8 months)  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed

*James McCulloch*

Licensed Embalmer No. 2444

P. O. Address

*175 Pellmo*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER IN HIS OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body was embalmed by me, it should be so stated above.

20/7/0